IDAHO DEPARTMENT OF
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August 31, 2006

Renee Mai, Administrator
Life Care Center of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406

Provider #: 135091

Dear Ms. Mai:

On **August 3, 2006**, a Complaint Investigation was conducted at Life Care Center of Idaho Falls. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. A total of nine survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001674

ALLEGATION #1:

The complainant stated that when an identified licensed nurse passes medications she does not give unidentified residents time to swallow the pills. The pills go down the front of their shirts.

FINDINGS:

During the investigation the name of the identified licensed nurse was revealed only to the Director of Nursing and the unit nurse manager. These two staff members were interviewed separately. Each stated the identified licensed nurse was a good employee. She was involved in a personality conflict with one aide who worked in the special care unit. Due to this conflict, the licensed nurse had recently asked not to work in the unit where the aide was assigned.

The facility's grievances and resident council minute notes were reviewed for the previous three months. There were no identified concerns regarding residents not receiving medications. The

facility's medication error records were reviewed. There were no documented medication errors regarding licensed nurses' techniques in administering medications.

The Director of Nursing and random staff were interviewed throughout the facility, to include the two licensed nurses identified in the complaint to be interviewed. There were no statements made by the staff regarding concerns about medication pass techniques as addressed in the complaint.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified licensed nurse places food trays in front of unidentified residents but if they do not start eating within five minutes, she takes their trays away and does not help them.

FINDINGS:

During the investigation the identified licensed nurse was not on duty. Direct care staff was interviewed, including the two licensed nurses who were identified to be interviewed. Each staff member stated licensed nurses were very attentive and kind to all the residents. At no time did they observe another staff remove a resident's tray without assisting the resident or allowing the resident time to eat. One random aide named four licensed nurses who were very good with residents; this included the name of the identified licensed nurse in the complaint. The Director of Nursing and the unit manager were interviewed. There had been no complaints by residents, family or staff regarding the identified licensed nurse.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident uses her call light frequently. An identified licensed nurse places the call light where the resident cannot reach it. When an identified certified nurse assistant attempted to put the call light within the resident's reach the licensed nurse told her to, "knock it off" and told the aide she would get her fired if she did it again.

FINDINGS:

The identified licensed nurse was not on duty at the time of the investigation. Random direct care staff was interviewed, to include the two licensed staff identified to be interviewed.

Each staff member stated they had not witnessed another staff member intentionally placing call lights out of residents' reach. They had not heard any staff member telling other staff to not place a call light within residents' reach.

During the investigation residents' call lights were observed to be within reach of residents. The facility's grievances and resident council minute notes did not identify this as a concern.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident has very contracted hands and is very embarrassed about it and does not want to go to the dining room. An identified licensed nurse makes the resident go to the dining room. The resident is humiliated and cries. She asks to go back to her room but the licensed nurse refuses to allow her to do so.

A second identified resident is quite anxious and asks repetitive questions. The licensed nurse told her if she were to remain quiet the entire meal then she would take the resident home with her. The resident stayed up until midnight waiting for the nurse. At the meal times the resident continued to ask the nurse, "where's your car?"

FINDINGS:

The first identified resident's record was reviewed. Her care plan identified she preferred to eat meals in her room. During the investigation, the resident was observed to eat her meal in her room. Random direct care staff stated the resident was always asked prior to meal time where she would like to eat her meal. All the staff honored her request. To their knowledge this resident had never been forced to have her meals in the dining room.

The second identified resident's care plan was reviewed. She had a history of asking repetitive questions due to very short term memory. She was not able to be interviewed. Random staff who worked in the special care unit were interviewed. Each staff stated they had not witnessed any staff person asking that a resident be quiet during a meal or offering to take the resident home with them.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified licensed nurse tells the aides not to give the residents water during her 12 hour shift because if they cough or choke she would need to suction them and she

does not want to do that.

FINDINGS:

The identified licensed nurse was not on duty during the investigation. Random direct care staff was interviewed, to include the two licensed staff identified to be interviewed. Each staff stated they had not witnessed any staff member withholding fluids from residents unless warranted. They had not been told to withhold fluids, or heard that other staff had been told to withhold fluids from residents.

Random charts were reviewed for residents residing in the special care unit. Specific meal monitor records were reviewed to correspond to the days the licensed nurse worked. Adequate fluids were received during these meals. There were no identified concerns regarding dehydration. During the investigation residents appeared well hydrated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser for

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj